Ohio Administrative Code

Rule 5160-28-04 FQHC and RHC services: submission of a cost report.

Effective: July 1, 2022

(A) Data entered into a cost report should represent "reasonable and allowable costs," which are defined in "Principles of reasonable cost reimbursement," 42 C.F.R. part 413 (October 1, 2021).

(B) For purposes of payment determination, an FQHC or RHC submits a cost report in any of the following circumstances:

(1) An FQHC or RHC that is newly enrolled as a medicaid provider submits a cost report covering the twelve-month period beginning either on the first day of the first calendar month or on the first day of the first full fiscal year after enrollment.

(2) An FQHC or RHC that requests an adjustment of a per-visit payment amount (PVPA) based on a change in scope of an existing FQHC or RHC PPS service submits a cost report for that service covering the twelve-month period beginning either on the first day of the first calendar month or on the first day of the first full fiscal year after the change in scope. If the adjustment is granted, the PVPA derived from the cost report becomes the new PVPA.

(3) An FQHC or RHC that has chosen to provide an additional PPS service (other than transportation) submits a cost report for that service covering the twelve-month period beginning either on the first day of the first calendar month or on the first day of the first full fiscal year after addition of the service.

(4) A government-operated FQHC that requests the alternate payment method (APM) described in rule 5160-28-07.1 of the Administrative Code submits cost reports in accordance with that rule.

(C) The Ohio department of medicaid (ODM) or its designee may perform a desk review or conduct a field audit of any cost report submitted and may request any supporting documentation it deems necessary.

(D) No extension will be granted for submission of cost reports. If an FQHC or RHC fails to submit a complete and accurate cost report within one hundred twenty days after the end of a reporting period, ODM may choose to take either or both of two courses of action:

(1) It may decline to make any adjustments to the established PVPA or PVPAs.

(2) It may impose a penalty of not more than five hundred dollars for each business day on which the cost report is late.

(E) An FQHC or RHC may request adjustment of a PVPA.

(1) In its request, it addresses in writing the following topics:

(a) It specifies the basis for the request, such as a change in scope of an existing service or the addition of a new service.

(b) It specifies which cost centers have been affected and why.

(c) It describes the steps it took to arrive at the conclusion that an adjustment would be the most efficient means of responding to cost changes.

(d) It provides documentation to support its request, such as a community needs assessment or other analysis.

(e) If the change in scope is directly attributable to a change in the intensity of services provided, then the FQHC or RHC provides evidence such as a change in the acuity of care caused by a shift in the distribution of diagnoses or a change in the relative-value components of the services provided.

(f) An FQHC that is adding a PPS service submits to ODM a copy of the notice of grant award authorization from the federal health resources and services administration (HRSA) confirming that its sites satisfy HRSA criteria for providing the new PPS service it plans to render.

(2) ODM has sole discretion over whether to grant a request for adjustment of a PVPA.

(F) ODM will respond in writing within sixty days after it receives a request for an adjustment of a PVPA based on a change in scope or after it receives additional information needed to determine whether an adjustment is warranted.

(G) The following conditions apply to any adjustment of a PVPA based on a change in scope:

(1) Such an adjustment can be granted only once for a particular circumstance for a particular FQHC or RHC service site.

(2) No adjustment will be made if the percentage of change represented by the calculated PVPA for the service is not at least twice the medicare economic index (MEI) for the relevant year.

(3) No adjusted PVPA may exceed any limit, ceiling, or other maximum set forth in agency 5160 of the Administrative Code.